ACUTE HEPATITIS C VIRUS AND THE CARDIAC SURGEON: AN EXPLANATION NEEDED

To the Editor:

I read with great interest the recent editorial by Thurston[1] addressing an important point, namely the eventual acquisition of hepatitis C virus (HCV) in the operating room by a practicing surgeon. This threat can be extended to other pathogens, such as hepatitis B virus, HIV, or *Mycobacterium tuberculosis*. Not only attending surgeons but also assistants, scrub nurses, anesthesiologists, perfusionists, and operating room staff in general are usually at risk.

The review by Thurston[1] after his personal negative experience with HCV has to be taken into account because this unexpected event does happen. Transmission to a health care worker is an old problem and is of particular importance with hepatitis, as already discussed by Fry[2] in a thorough review. Fry identified different types of risk, with hepatitis as the real threat and HIV as an emotional threat. Two decades later, his statements continue to hold value. Surgical intervention carries continued occupational risks.

I personally share and endorse Thurston's points. I first became tested for viruses after being exposed to intraoperative blood spillage while operating on an HIV-infected patient in the late 1980s.[3] A few years later, I underwent postexposure prophylaxis after another unexpected occupational exposure. Fortunately, I have always had and continue to have negative test results for HCV and HIV. Some other colleagues that I know have gone through similar experiences. During the past 25 years, we have accumulated experience in treating patients infected with HCV and HIV because coinfection rates were in excess of 60% in my country,[4] with intravenous drug abuse as the main risk factor for the acquisition of both viruses.[5]

What is surprising to me in Thurston's editorial[1] is a very brief statement close to the end after the mention of the stance of the American College of Surgeons. One can read the following: ''…It has been suggested that because of the high incidence of cardiac surgeon injury during closure with sternal wires, perhaps an assistant should close….'' To me, it is a must for the author to clearly state to whom these words belong. This is an extraordinarily offensive statement that requires confirmation and an appropriate reference in the reference list. The reader must know whether this statement is supported by a previous publication, whether this is the opinion of the author, or whether it is just an overheard comment from a private conversation. This is, of course, not my personal policy. Such a statement is highly misleading. The risk of contamination involves all the staff in the operating room. Handling any type of needle is a critical occupational risk; therefore, extreme care must be taken at the time of recommendations or advice. Perhaps some senior surgeons have completely forgotten the old days when they were assistants. Furthermore, care should be taken, too, because editorials are usually endorsed by the editorial office.

I once again support and endorse the call for attention to this particular matter given by the author.

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Reply to the Editor:

Thank you for your response concerning my editorial on hepatitis C virus. The statement to which you refer is a suggestion referable to a cardiac surgeon who continues to be hepatitis C virus positive and wishes to keep operating. In this specific circumstance, it might be that the low incidence of surgeon-to-patient transmission could be further reduced by eliminating the surgeon's handling of sternal wires. This is supposition only.

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